Disclaimer:

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Learning Objectives

Participants will be able to:

- Identify and assess gaps in transitions of care for PBHCI clients.
- Learn strategies to leverage community networks to decrease gaps in services and increase warm hand offs for clients.
- Understand frameworks for developing innovative partnerships with local organizations serving their clients

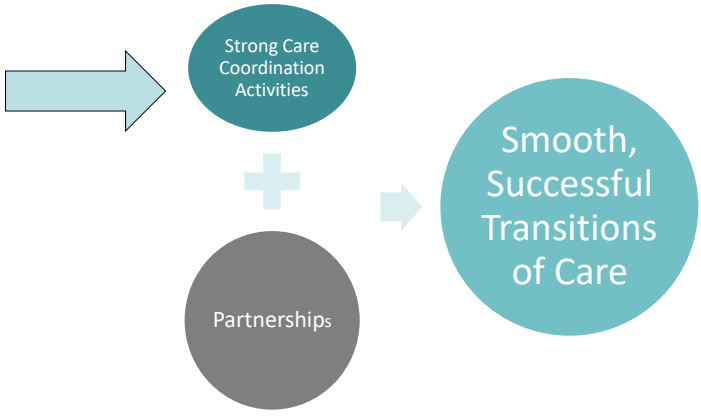
Centers for Medicare & Medicaid Services (CMS) defines a transition of care as:

- The **movement** of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
- These transitions place patients at heightened risk of adverse events. Important information can be lost or miscommunicated as responsibility is given to new parties.
- Unsafe transitions of care from the hospital to the community are common and frequently associated with post discharge adverse events (Forster, et al., 2003).
  - Higher readmission rates
  - Decreased patient and family satisfaction
  - Staff morale and attitude

Why Focus on Transitions of Care?

- Better quality of care for the patient and family
- Continuity of care
- Improved outcomes
  - Better utilization of services across systems
  - Financial incentives

Components of Transitions of Care: Care Coordination



Challenges to Effective Transitions of Care

- Lack of client and family engagement in process
- Inconsistent communication
- Confusion/disagreement about discharge plan/ treatment plan
- Lack of partnerships
- Lack of care coordination
- Competing needs (bed space needs, court related deadlines, staff availability)
- Barriers to accessing services
  - Location, transportation, financial

Taking a Deeper Look at Challenges

Areas to Consider	Internal Perspective	External Perspective	Follow Up Action Items
Communication: 1. What type of communication do you use? 2. What process do you have in place for follow up? 3. Expectations regarding response time			
Treatment Planning: 1. If external partners participate what is the engagement process? 2. When do the teams start assessing transitions of care? 3. Are treatment teams assessing risk?			
Barriers: 1. How do staff identify barriers? 2. How do clients identify barriers?			
Client and Family Engagement: 1. How does the organization measure client and family engagement?			
Staff: 1. How do you assess staff competency in transitions of care? 2. Does staff understand impact? 3. How do you know your staff's			

First Step: Assess Your Process

- Observe
- Be the client
- Evaluate and Analyze
- Get feedback from all levels of staff
- Map out the process
- Ask community providers to provide feedback

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Second Step: Develop an Improved Process

- Update current policies around transitions of care
  - Highlight specific roles and responsibilities
  - Include timelines
- Create a checklist with input from inpatient and outpatient providers
- Design a provider resource manual for staff

Checklist to Use When Assessing the Process

Date of Discharge:

Person Collecting the Information:

Documentation Review:

Process	Yes	No	N/A
Reconciled medication list with possible side effects?			
Recived clear instructions for medication use ?			
Received a list of current diagnoses and treatments that occurred during hospital stay (if applicable)?			
Received written discharge plan of care ?			
Recived educational materials regarding medications or diagnoses (including a list of symptoms to watch for)?			
Received a list of pending labs or tests?			
Received the name and number of client's next care provider?			
Received emergency contact information?			
Had scheduled follow-up appointments and transportation arranged (check client is availibility)?			
Record sent to the next care provider?			
Next care provider has signed off on the plan?			
Was the next care provider involved in the plan? (see clinical notes)			
Plan provided to the client?			
Assessed client knowledge of care plan (language, timeline, barriers)?			
Client legal guardian/POA involved as needed?			
Client sign off on the plan?			
Within the record, was there evidence that:			
-The record was sent to the next care provider Y/N			
-If the patient was high risk, there was a follow-up visit within 48 hours of discharge			
If readmitted within 30 days of discharge/transitions			
-Did the client make their follow-up appointments Y/N			
-If no, list the reasons why: transportation? Financial? Different admitting diagnoses? Lack of medications?			

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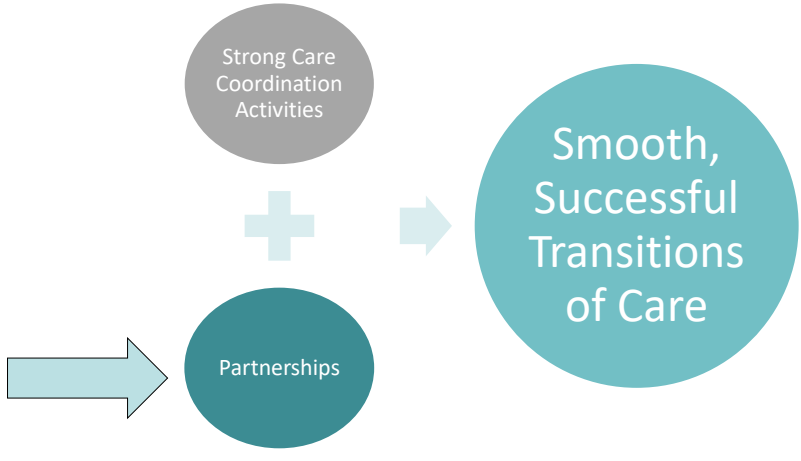
Partnerships

" Our success has really been based on partnerships from the very beginning."

-Bill Gates

Another Crucial Component is Partnerships



Ways to Foster Partnerships

- Know what other providers offer and what they do well
- Identify potential barriers to your partnership
  - Past history
  - Government agency vs. community agency
- Know/engage community partners across continuum of care
- Identify goal of partnership
  - Need each other to help achieve goals
- Develop a relationship with at least one pharmacy
- Understand their expectations and share your expectations
  - No hidden agendas– be completely transparent

http://ctb.ku.edu/en/creating-and-maintaining-partnerships

Ways to Maintain the Partnerships

- Consistent structured meetings
- Create communication expectations/standards
- Develop processes for expeditated referrals
- Collaboration on treatment and discharge planning
- Real-time communication between inpatient & outpatient

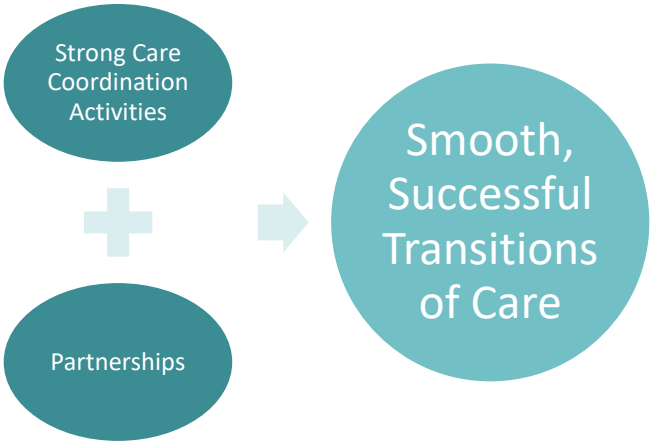
Person and Family Engagement

- Recovery Model Perspective
- Help patients gain the knowledge and skills to advocate for themselves, their family, children, etc.
- Learn to ways to navigate transitions of care independently

Easy Action Steps

- Hire Peer Support Staff
- Identify a dedicated staff to monitor transitions of care
- Collect data on discharge plans of care, readmissions, and patient surveys
- Schedule an ongoing meeting with partners
- Create peer focus groups
- Use data in supervision, staff meetings

How It All Comes Together



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Partnering for Successful Transitions of Care

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TRILOGY
BEHAVIORAL HEALTHCARE

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Dr. Geis is the Director of Integrated Health at Trilogy Behavioral Healthcare, a community mental health center in Chicago. She is an Assistant Professor at Rush University, where she teaches in the master's and doctoral programs. She is board certified as a Psychiatric-Mental Health Nurse Practitioner, with doctoral preparation in Systems Leadership nursing. She has held a number of clinical, administrative, academic and consulting roles, including director of a hospital-based psychiatric home care program, member of a United Nations team investigating war crimes in the former Yugoslavia, and program development consultant.

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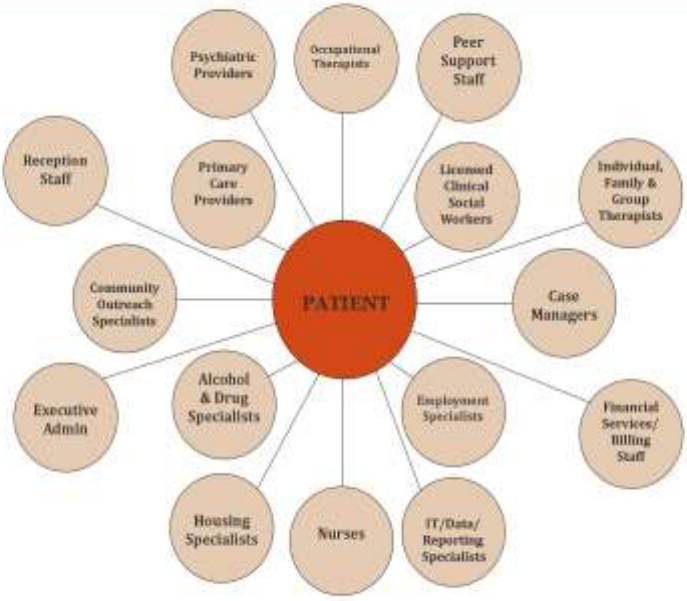
INTEGRATED CARE TEAM



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Reciprocal Benefits in this Model

- Community behavioral health organizations (CBHOs) need to provide well-coordinated care to a population of people with serious mental illness, multiple medical comorbidities, and a high rate of substance use disorders
- Federally-qualified health centers (FQHCs) need psychiatric expertise and outreach services to best treat people with mental illness
- CBHOs and FQHCs both need qualified NPs, MDs, RNs SWs, & others who are prepared to work interprofessionally in integrated settings
- Academic programs which prepare health professionals need clinical placement for students which support entry into the workforce

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Strategies for Building Viable Partnerships

- Shared vision and values is vital
- OK to start small; MOU, referral relationships
- Consider treatment frameworks as well as leadership styles and structures
- Interprofessional training environment can support provider satisfaction, recruitment and retention
- Align with academic practice programs: cost-effective way to procure administrative, clinical, or research expertise
- Faculty embedded in CBHO or FQHC can support best use of students at various levels

What kinds of gaps in care do we see?

- Inadequate communication at time of transition
- Medication reconciliation problems
- Disconnect between PBHCI provider view of care needs and acute care determination of need

Factors Contributing to these Gaps

- Acuity of psychiatric, medical, and substance use disorders often requires skilled home health care, often not available
- RN and OT are integral services in this model, often not reimbursed in a way which allows for sustainability
- Coordination with acute inpatient services lags

How can partnerships help?

- Promote improved transfer of information
- Allow for identification of shared priorities
- Enable efficiencies in care transitions
- Building working relationships across systems
- Maintaining organizational strength through workforce development

Partnerships Can Support Staffing

Being a clinical site for 100s of students has led to

- 25,337 clinical hours of service by nursing students alone
- 3167 average # of clinical care hours per year, or
- the equivalent of 1.5 FTE/year
- 11 RNs and 3 psych provider former students hired

An Example of Leveraging Partnerships

- Consent decree transition programs
  - Clients from psychiatric nursing homes ("Williams")
  - SNFs – clients with additional medical comorbidities ("Colbert")
- Collaboration between primary care and psychiatry
- Drawing support from additional partners or other organizations

Questions